

November 20, 2002

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-0256-01
IRO #: 5251

____ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ____ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed MD with a specialty and board certification in Orthopedic Surgery. The ____ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ____ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

____ is now an 64-year-old male who has worked in a position where he has used his upper extremities for repetitive straining activities while making tools. He has done this for many years and he developed symptoms in both upper extremities. He complained of carpal tunnel syndrome symptoms in his wrists along with pain and inability to fully elevate both shoulders. He consulted ____ who is an orthopedic surgeon on 11/8/00. She felt that he had bilateral carpal tunnel syndrome and she made a definitive diagnosis of bilateral subacromial impingement syndrome in both shoulders, worse on the right side. The record reflects that the right shoulder became more severe and she treated it several times with subacromial steroid injection. Each time the symptoms would improve and then return to the pre-injection level within a week or so. The patient had an MRI of the right shoulder which demonstrated evidence of tendinosis with acromioclavicular spurring and a possible partial tear of the supraspinatus tendon. These findings would be classic in a case of subacromial impingement syndrome which was ____' diagnosis. She then recommended an acromioplasty with shoulder decompression and repair of the rotator cuff if indicated. The insurance carrier and its physician's advisors have denied this.

REQUESTED SERVICE

Right shoulder neer acromioplasty is requested for ____.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

Some of the reasons cited were that there was no provided record of a comprehensive approach to rotator cuff strengthening through physical therapy. Also, the physician's advisor suggested that the patient might have an adhesive casulitis. The clinical findings described by ____ of crepitus in the shoulder with abduction limited at 110 degrees along with a temporary relief of symptoms with subacromial steroid injection are classic symptoms of subacromial impingement syndrome. This patient does not clinically have adhesive capsulitis. He is able to abduct his shoulder to 110 degrees, then pain limits the abduction at that point in time. Further physical therapy to attempt to improve his pain in the shoulder and his range of motion is not indicated and would probably make the symptoms worse.

The ____ reviewer agrees with the patient's attending physician, _____. He finds that surgical acromioplasty with right shoulder decompression and repair of the rotator cuff as indicated is the treatment of choice, and he does not believe that any other treatment will offer this patient any significant degree of relief.

As an officer of ____, I certify that there is no known conflict between the reviewer, ____ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

____ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 20th day of November 2002.